09728
09723 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09724

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: PRESTON	Middle: AYARS	Last: SR.	2a. DATE OF DEATH Month: 7- Day: 10 Year: 69	2b. HOUR: 1205 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: FEB. 26, 1894	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): DELAWARE	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): UNION HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): DUPONT Co	12b. KIND OF BUSINESS OR INDUSTRY: ADMIN.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: CECIL	13c. CITY OR TOWN: ELKTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RED BERRY HILL	
14. FATHER'S NAME First: J. HAMILTON	Middle:	Last: AYARS	15. MOTHER'S MAIDEN NAME First: EMMA	Middle: L.	Last: FEHRENBACH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 221-01-4680	17. INFORMANT: PRESTON AYARS Jr.	Address: SMITHTOWN, L.I. N.Y.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Years
4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from 7-5-, 1969, to 7-10, 1969, that (I) (we) last saw the deceased alive an 7-10- 1969, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Tillman D. Johnson	M.D.	☑	☐	☐	7-11-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Tillman D. Johnson, M.D	128 Sincerely Ave., Elkton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	JULY 14, 1969	RIVERVIEW CEM	WILMINGTON	N. CASTLE	DEL.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON, Md.	JUL 14 1969	Charles Judge

VR A15 (4)
30M REV. 1/68

[redacted] 09725

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09725

1. DECEASED-NAME (Type or print) First	Middle	Lost
Floyd	G.	Barkuloo

2a. DATE OF DEATH Month	Day	Year	2b. HOUR
July	18	1969	9:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	April 17, 1902	67 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Wis.	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
North East	R.D. #2	Marine Mech.	Boating

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
Md.	Cecil	North East		R.D. # 2

14. FATHER'S NAME First Middle Lost	15. MOTHER'S MAIDEN NAME First Middle Lost
William H. Barkuloo	Susie M. Goodier

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	503-07-0573	Mary A. Barkuloo	North East, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	
DUE TO, OR AS A CONSEQUENCE OF		
(b)	Arteriosclerotic cardiovascular disease	
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

4109

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) attended the deceased from 7-18, 1969, to 7-18, 1969, that (I) (we) last saw the deceased alive on 7-18 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Jay S. Barnhart, Jr.	MD	[X]	[ ]	[ ]	7-19-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jay S. Barnhart Jr.	4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-22-69	West Nottingham Cem.	Colora Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul P. Crouch	Box 250 North East, Md.	JUL 22 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

[redacted] 09730

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09726

[redacted] MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First: BARRY	Middle: THOMAS	Last: Bernhard BERNARD	2a. DATE KNOWN OF DEATH / DATE ESTIMATED: Month 7 Day 21 Year 1969	2b. HOUR: 5:55 PM		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 4/28/51	6. AGE (In years last birthday): 18 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 7 Day 21 Year 1969	2d. HOUR: 5:55 PM	
7a. BIRTHPLACE (State or foreign country): P.A.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil	Md.		
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNION HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): STUDENT	12b. KIND OF BUSINESS OR INDUSTRY: School			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: CECIL	13c. CITY OR TOWN: NORTHEAST	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D. #2		
14. FATHER'S NAME First: James	Middle: J.	Last: Bernhard	15. MOTHER'S MAIDEN NAME First: Catherine	Middle: J.	Last: Raine, North East Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-58-0928	17. INFORMANT: Charles H. Raine	ADDRESS: North East, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	FRACTURED CERVICAL VERTEBRAE	INST
DUE TO, OR AS A CONSEQUENCE OF (b)	812.2 MALEFT SHOULDER LACERATIONS LEFT ARM AND LEG	INST
DUE TO, OR AS A CONSEQUENCE OF (c)	MOTORCYCLE, TRUCK COLLISION	7/21/69 Stat.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5:45 P.M. 7/21 1969	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): MOTORCYCLE-TRUCK COLLISION
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): STREET	21f. LOCATION Street or R.F.D. No.: JUNCTION 279-280 City or Town: ELKTON County: CECIL State: MD

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis M.D.
EXAMINER'S NAME (Type): HENRY V. DAVIS M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): CHESAPEAKE CITY MD
22b. DATE SIGNED: 7/21/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-25-69	North East Meth.	North East Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home	Paul R. Prouch North East, Md.	JUL 24 1969	Charles Judge

VR A15ME (5)
10M REV. 1968

[redacted] 09731

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09727

1. DECEASED-NAME (Type or print) First / Middle / Last	WILLIAM S. BLACKSTOCK		2a. DATE OF DEATH Month / Day / Year	July 21, 1969	2b. HOUR 7:45 P.M.
3. SEX	Male	4. RACE	White	5. DATE OF BIRTH	[redacted] 9-21-22
6. AGE (In years last birthday)	46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Balto.,Md	7b. CITIZEN OF WHAT COUNTRY?	U.S.S.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH	Perry Point,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	VAH, Perry Point, Md.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Handy man
12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md	13b. COUNTY	—	13c. CITY OR TOWN	Baltimore
13d. INSIDE CITY LIMITS?	YES [X] NO [ ]	13e. STREET AND NUMBER	3027 Hamilton Avenue		
14. FATHER'S NAME First / Middle / Last	Benjamin Blackstock			15. MOTHER'S MAIDEN NAME First / Middle / Last	Olive Scott
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	Yes	(If yes give war or dates of service)	WW II	16b. SOCIAL SECURITY NO.	216 18 08 94
17. INFORMANT Address	VA Records, VAH, Perry Point, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia, left lung, severe

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic coronary artery disease with myocardial fibrosis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 7-2- , 1969 , to 7-21- , 1969 , that ~~I~~ (we) last saw the deceased alive on 7-21- 1969, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	A. L. Mooney, M.D.	DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]		22c. DATE SIGNED	7-22-69
22d. PHYSICIAN'S NAME (Type)	A. L. MOONEY, M.D.			22e. ADDRESS	VAH, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	7/24/69	Baltimore, [redacted]	Baltimore, Maryland	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
LEONARD J. RUCK	5305 Harford Rd.,Balto, Md.	JUL 24 1969	[signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (1)
45M - 1-69

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09732

CERTIFICATE OF DEATH

09728

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Starr	Oakley	Bragg	July	31,	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	August 4, 1915	53 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
West Virginia	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Chrysler Corp.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER
Maryland	Cecil	Elkton		139 E. MAIn Streeet

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Peter	Gaston	Bragg	Leona		Bucklin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address	
No	232-28-6717	Mrs. Hazel V. Bragg, 139 E. Main St.	Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) — Congestive Heart Failure due to Uremia
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF (c) Polycystic Kidneys
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June 1967, to 7/31, 1969, that (I) (we) last saw the deceased alive on 7/3, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph G. Lanzi		[X]	[ ]	[X]	7/31/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Joseph G. Lanzi, M.D.	Elkton Medical Park, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8/3/69	Tilden Community Cemetery	Ward Hill, West Virginia

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	Hicks Home for Funerals, Elkton, Md.	AUG 4 1969	Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

[redacted] 09733

CERTIFICATE OF DEATH

09729

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CHARLES		BROOKS	7 9 69	2:15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
M	NEGRO	2-7-95	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
MARYLAND	U.S.A.		SP. CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	CECIL	WARWICK	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT		BROOKS	CAROLINE		FREEMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes	WWI	212-14-9253	William H. Brooks	Warrick, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PARESIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b) LUES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NONE		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 6/26, 1969, to 7/9, 1969, that (I) (we) last saw the deceased alive on July 9, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Henry V. Davis		☒	☐	☐	7/9/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
HENRY V. DAVIS	CHESAPEAKE CITY Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/12/69	Cecilton Cem.	Cecilton, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Calvin R. Bell	909 Poplar St.	JUL 14 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 11-68

[redacted] 09734

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09730

1. DECEASED-NAME (Type or print): First SARA Middle McKee Last COOKE
2a. DATE OF DEATH: Month 7 Day 24 Year 69
2b. HOUR: 330 P.M.
3. SEX: Female
4. RACE: WHITE
5. DATE OF BIRTH: Jan 15, 1910
6. AGE (In years last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Tenna.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: ELKTON
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Union
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House Wife
12b. KIND OF BUSINESS OR INDUSTRY: At Home
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Cecil
13c. CITY OR TOWN: ELKTON
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: RD #1 ELKTON
14. FATHER'S NAME First DE VEAUX Middle Mc KEE Last
15. MOTHER'S MAIDEN NAME First Bonnie Middle Last Hamilton
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 062-14-1965
17. INFORMANT: John C. Cooke Jr. Address: RD #1 ELKTON Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA Tongue — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Year
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost. 141.9
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Laennec's Cirrhosis of liver

19a. DATE OF OPERATION: 3/6/69
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Biopsy Tongue
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ☐ ot work Not while ☐ ot work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this haspital) attended the deceased from 3/2, 19 69, to 7/23, 19 69, that (I) (we) last saw the deceased alive an 7/23 19 69, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: John A Fischer M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 7/25/69
22d. PHYSICIAN'S NAME (Type): John A Fischer.
22e. ADDRESS: ELKTON, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE: 7/28/69
23c. NAME OF CEMETERY OR CREMATORY: SILVERBROOK CREMATORY
23d. LOCATION (City or Town) (County) (State): WILMINGTON DEL.
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME ADDRESS: ELKTON MD
25a. REC'D BY REGISTRAR DATE: JUL 29 1969
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09735 09731

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Clarence		Culley	July	29	1969	6:15 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Male	White	May 24, 1910	59 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Custodian	School

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	North East	YES ☒ NO ☐	9 W. Cecil Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Theodore		Culley	Susie		Tasker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes WW II	217-09-5007	Warner W. Culley	805 Elkton, Rd. Newark, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure + pulmonary edema
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic bronchitis; hypothyroidism.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 9-17, 1965, to 7-15, 1969, that (I) (~~we~~) last saw the deceased alive on 7-15 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE	M.D. DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Jay S. Barnhart Jr.					7-29-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jay S. Barnhart Jr.	4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-31-69	Pleasant Grove	Peach Bottom Chester Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Grant Funeral Home Paul R. Grant	Box 250 North East, Md.	AUG 1 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farworded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. T/68

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09732

1. DECEASED-NAME (Type or Print) 09736	First ROBERT	Middle A.	Last DODSON	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐	Month July	Day 8,	Year 1969	2b. HOUR 10 :50			
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 20, 1946	6. AGE (In years last birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month July	Day 8.	Year 1969	2d. HOUR M

7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH Cecil Md.

10. CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman	12b. KIND OF BUSINESS OR INDUSTRY Insurance

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE New Jersey	13b. COUNTY Camden	13c. CITY OR TOWN Lindenwold	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER 19 S. Coachman Manor Apts. 401 Goldsboro Road

14. FATHER'S NAME	First Melvin	Middle W.	Last Dodson	15. MOTHER'S MAIDEN NAME	First Frances	Middle B.	Last Klancic	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes	(If yes give war or dates of service) 1967-68	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS Lindenwold, N.J.			Apts.	
			Mrs. Judith A. Dodson, 19 S. Coachman Manor					

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Multiple TraumaticInjuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

8129

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 2:00 xx P.M. 7-4- 19 69	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject involved in auto-auto collision	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street	21f. LOCATION Street or R.F.D. No. Rt.40	City or Town Elkton	County Cecil	State M.D.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Ronald N Kornblum M.D.

EXAMINER'S NAME (Type) ROnald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 7/9/69

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 7/12/69	23c. NAME OF CEMETERY OR CREMATORY Berlin Cemetery	23d. LOCATION (City or Town) Berlin,	(County) Camden,	(State) N.J.

24. FUNERAL DIRECTOR Ralph E. Hicks	ADDRESS Hicks Home for Funerals, Elkton, Md.	25a. REC'D BY REGISTRAR DATE JUL 11 1969	25b. REGISTRAR'S SIGNATURE Charles Savage

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09737

CERTIFICATE OF DEATH

09733

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GILBERT	B.	FOSTER	7-2-69	10-55 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
M	W	5-27-06	63 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Cecil County	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Cecil County, Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hosp.	Retired	—

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Chesapeake City	YES [X] NO [ ]	RD#1 Box 18D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Amos		Gilbert	Julia	Kloyd.	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	109-12-4407	MRS. DORIS E. FOSTER CHESAPEAKE CITY MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Peritonitis.
DUE TO, OR AS A CONSEQUENCE OF (b) Perforated Viscus
DUE TO, OR AS A CONSEQUENCE OF (c) Peptic ulcer.

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 5311

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 days.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
6-24-69	Perforated ulcer.	YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** thot (I) (this hospitol) attended the deceased from 6-20-, 1969, to 7-2-, 1969, that (I) (we) los sow the deceased alive an _____ 19___, and that in (my) (our) opinion deoth occurred an the dote ond haur ond from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Cristobal Vela, M.D. DEGREE	[X]	[ ]	[ ]	7-2-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
CRISTOBAL VELA, MD.	123 W. High St. Elkton Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	7-5-69	Bethel	Chesapeake City Cecil MD

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
R. T. Ford Funeral Home Chesapeake City MD	JUL 7 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and thereafter, within 72 hours after death.

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

[redacted] 09738

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09734

1. DECEASED-NAME (Type or Print)	First: ROBIN	Middle: RICHARD	Last: FRAZIER					2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☒	Month: 7	Day: 16	Year: 1969	2b. HOUR: 6:45 P.M.
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: Jan 8 1954	6. AGE (In years last birthday): 15 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.			2c. DATE PRONOUNCED DEAD	Month: JULY	Day: 16	Year: 1969	2d. HOUR: 5:45 P.M.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.									
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNION HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER	12b. KIND OF BUSINESS OR INDUSTRY: FARMING									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: DEL.	13b. COUNTY: NEWCASTLE	13c. CITY OR TOWN: MIDDLETOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D. #2								
14. FATHER'S NAME	First: GEORGE	Middle:	Last: FRAZER	15. MOTHER'S MAIDEN NAME	First: MABLE	Middle:	Last: GUHL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MR. GEORGE FRAZER	ADDRESS: MIDDLETOWN, DEL								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CRUSHING CHEST AND ABDOMINAL INJURY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR
DUE TO, OR AS A CONSEQUENCE OF
(b): RUN OVER BY FARM TRACTOR
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 917X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year: HOUR AM 4:30 P.M. 7/16/1969	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18): FELL OFF MOVING TRACTOR AND RUN OVER BY THE REAR WHEEL
21d. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): FARM	21f. LOCATION Street or R.F.D. No.: RURAL FARM — City or Town: UNION — County: CECIL — State: MD

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☐, and in my apinian death resulted fram: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis M.D.
EXAMINER'S NAME (Type): HENRY V. DAVIS MD
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): CHESAPEAKE CITY MD
22b. DATE SIGNED: 7/16/69

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: July 20, 1969	23c. NAME OF CEMETERY OR CREMATORY: St. Augustine Cem	23d. LOCATION (City or Town): St Augustine	(County):	(State): MD.
24. FUNERAL DIRECTOR: G. Lester Daniels	ADDRESS: Middletown, Del	25a. REC'D BY REGISTRAR DATE: AUG 4 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

[redacted] 09739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09735

1. DECEASED-NAME (Type or Print) First	Middle	Last
CONLEY	VAUGHN	GILLEY

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 7/4 Day Year 1969 — 2b. HOUR M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.
Male	White	April 20, '20	49 YRS.				

2c. DATE PRONOUNCED DEAD Month July Day 4. Year 1969 — 2d. HOUR 3:10 A.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
North Carolina	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Maintenance Man	Civil Ser.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Port Deposit	YES [X] NO [ ]	Rd. #1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Arthur		Gilley	Calley		Wyatt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	W.W. I	199-05-9688	Mrs. Conley Gilley	Port Deposit, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8120

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	2:10 xxx 7-4 1969	Driver in auto-auto collision

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Highway	Rt. #40 2 miles West of Elkton		Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED July 4, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/7/1969	West Nottingham Cem.	Colora, Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Vernon E. Mueller	Rising Sun Md.	JUL 8 1969	Charles Judge

VR A15ME (5) 10M REV. 1/68

Item 2a Film G114 7/2/69 kk

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09736

[redacted] MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09740

1. DECEASED-NAME (Type or Print) First	Middle	Lost
THOMAS	RAY	GRANT

2a. DATE KNOWN OF DEATH ESTIMATED ☐ — Month: 7 — Day: 10 — Year: 1969
2b. HOUR: 8:25 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	IF UNDER 1 YEAR: DAYS	IF UNDER 24 HRS.: HOURS	IF UNDER 24 HRS.: MIN.
Male	White	9/24/1942	26 YRS.				

2c. DATE PRONOUNCED DEAD — Month: July — Day: 10 — Year: 19 69
2d. HOUR: 8:26 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. Virginia	U.S.A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Job Trainer	Gen. Motors

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Delaware	New Castle	New Castle	YES ☒ NO ☐	10 Ivy Lane

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Robert	David	Grant	Winona		(Grant)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		233-70-2600	Sharon R. Grant - 10 Ivy Lane, New Castle, Dela.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 823X
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	8:40 P.M. 7 4 19 69	Subject injured in his racing car

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Drag strip	Drag Strip, Bayview		Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county) Deputy Chief Medical Examiner

22b. **DATE SIGNED** July 11, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/14/69	Boone Memorial Park	Madison, West Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William J. Warwick 121 W. Park Place Newark, Dela. 19711	JUL 16 1969	[signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09741

CERTIFICATE OF DEATH

09737

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	C.	HOLLAND	JULY 18 1969	9:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	NEGRO	12-3-1886	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Balto., Md	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	Perry Point, Md	Retired	Post Offic

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD		Baltimore	YES ☒ NO ☐	2512 W. Lanvale

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Robert	William	Holland	Sarah	Holland	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW I	217 54 83 69	VA Records, VAH, Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma left lung (lower lobe)	
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic brain syndrome associated with cerebral	
DUE TO, OR AS A CONSEQUENCE OF (c)	arteriosclerosis	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 6-24- , 1959 , to 7-18- , 1969 , that (I) (we) last saw the deceased alive on 7-18- 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
J Reus M D		☐	☐	☒	7-18-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
I. REUS, M.D.	VAH, PERRY POINT, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-23-69	Balto. Nat'l Cem.	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MORTON & DYETT F.H. 1701 Laurens St.	JUL 22 1969	J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (45M - 7-68)

[redacted] 09742

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09738

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR	
GLADYS	DIGGS	HOLT	JULY	8	1969	6:05A	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	White	Aug. 14, 1899	69 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Balt., Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Office Manager	Retail

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	North East	YES ☐ NO ☒	Hances Point

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank		Diggs	No Info.		Spies

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	222-20-2381	Harold W. Holt, Hances Point, North East, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized metastatic disease

174X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the breast.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospitol) attended the deceased from 6-23, 19 69, to 7-2, 19 69, thot (I) (we) lost saw the deceased alive on 7-8 19 69, ond that in (my) (aur) opinion death occurred an the date and haur and fram the causes stated abave. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Jay S. Barnhart Jr.	M.D.	☒	☐	☐	7-8-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Jay S. Barnhart, Jr. M.D.	3 Mauldin Avenue, North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	July 10, 1969	Union Cemetery	Union	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME Donald R. Pippin	Elkton, Md.	JUL 9 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09743

CERTIFICATE OF DEATH

09739

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Marie	Boyer	Jones	7	17	69	4:20 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	Negro	8/4/40	28 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	United States		Cecil Co. Md. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union of Cecil Co.	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	Cecil	Conowingo		R.F.D. #1

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Sherman	=====	Boyer	Annie	=====	Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	213-38-5700	Alexander Jones	Conowingo, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INTESTINAL OBSTRUCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO, OR AS A CONSEQUENCE OF
(b) METASTATIC CARCINOMA OVARY.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 1968, 19 68, to present, 19 69, that (I) (we) last saw the deceased alive on 16 July 1969, and that in (my) (~~our~~) opinion death occurred on the date and haur and from the causes stated above, (I) (~~we~~) (did) (did not) view the body after death.

22b. SIGNATURE	M.D DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
Robert L. Gray					7/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert L. Gray M.D.	123 W. High St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	7--20--69	Mt. Zoar A.M.E. Cem.	Conowingo	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Orman E. McMullen	Rising Sun, Md.	JUL 22 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09744

CERTIFICATE OF DEATH

09740

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Alton		Kauffman	July 12 1969	9:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	March 11, 1904	65 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Pennsylvania	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cecilton	None	Asst. Foreman	Oil Refining

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pennsylvania	Delaware	Lindwood	YES [X] NO [ ]	1937 Huddel Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob		Kauffman	Cathrine		Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Name) (Address)
No	163-07-1191	1937 Huddle Ave. Bessie Kauffman Lindwood, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Acute coronary occlusion with massive infarction and asystole

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** thot (I) (this hospital) ottended the deceased from 12 July, 1969, to 12 July, 1969, that (I) (we) last saw the deceased olive an 12 July 69 19___, and thot in (my) (our) opinion deoth occurred on the date and haur ond from the causes stoted above. (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wallace Obenshain M.D		[ ]	[ ]	[ ]	14 July 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Wallace G. Obenshain M.D.	Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	July, 16, 1969	Edgewood Cemetery	Glenmills		Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edward Fellows	Millington, Md.	JUL 18 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, crematian, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09741

Item5 Film G415 8/1/69 kk [redacted] CERTIFICATE OF DEATH

09745

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
Ethel	Elizabeth	Kauffman	July 29 1969	10:15

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	August 12, 1914	54 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Pa.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Colora		Welder	Razor Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Colora	YES [ ] NO [X]	

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Norman		Kauffman	Unknown		Unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	214-12-0928	Jerry Carr	Colora, Md. 21917

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF

(b) Primary adenocarcinoma of colon — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 153.8

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 2-5, 1969, to 7-29, 1969, that (I) (we) last saw the deceased alive on 7-28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Neil A Taylor	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	7-29-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil A Taylor Jr	Rising Sun, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Aug 1, 1969	Conowingo Cemetery	Conowingo Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Edmon E. McMullen	Rising Sun, Md	AUG 1 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09746 09742

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Ernest	J	Kendall	July 18 1969	1:35

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
male	white	8/29/94	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Vermont	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Supt. Maintenance	School

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pennsylvania	Chester	Kennett Square	YES [X] NO [ ]	218 Marshall Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John		Kendall	Caroline		West

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	221-03-1768	Mrs. Lydia B. Kendall, Kennett Square, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 years
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
further acute infarction 7/9/69 congestive failure left vent aneurysm

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9 July, 19 69, to 16 July, 19 69, that (I) (we) last saw the deceased alive on 16 July 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Wallace Obenshain	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	16 July 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Wallace Obenshain, M.D.	Cecilton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/20/69	Evergreen Cemetery	South Strafford, Vermont

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	JUL 22 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09747

CERTIFICATE OF DEATH

09743

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ROBERT	D.	LEEDY, Sr.	JULY 20, 1969	9:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	9-11-04	64 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VAH, Perry Point, Md	Plasterer	Building

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Pro Geo	Bradbury Hts.	YES ☒ NO ☐	4817 U St., SE

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Thomas		Leedy	Mattie		Chapman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW II	577 18 72 21	VA Records, VAH, Perry Point, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 6--2, 1969, to 7-20-, 1969, that ~~I~~ (we) last saw the deceased alive on 7-20- 1969, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above. ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Beatrice A. Denefield		☐	☐	☒	7-21-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
BEATRICE A. DENEFIELD, M.D.	VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 24,1969	Fort Lincoln Cemetery	Colmar Manor, P.G. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
FRANCIS GASCH & SON	Baltimore, Ave. Hyattsville, Maryland	JUL 28 1969	Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 141
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09744

Item#5, FilmG414 7/11

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
09745 PETER	~~LOBURAK~~	LOBURK	X	July	3	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
Male	White	June 14, 1919	50 YRS.			July 3 19 69	9:10 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	USA		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Chesapeake City	Chesapeake City, M.D.	BAKER	BAKING

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO X	13e. STREET AND NUMBER
Md.	Cecil	Chesapeake		Chesapeake City, M.D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
NICHOLAS	LOBURK		NORA		SZADEK

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO	094-01-4992	ELIZABETH V. LOBURK	CHESAPEAKE CITY, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4124
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES XX / NO

21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy XX, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes XX, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER XX
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED July 3, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7/7/69	St Rose of Lima	Chesapeake City, Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Pippin Funeral Home	Elkton Md	JUL 8 1969	William S. Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forworded to the Chief Medical Exominer's Office along with Form PM3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as o burial-transit permit. File pages 1 and 2 with the State Department of Health prior to buriol, cremotion, or removal, and in ony event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

FOR STATE HEALTH DEPT.

09749 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09745

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month	Day	Year	2b. HOUR
JAMES	N.	LOVE	July	10	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	Negro	10-11-25	43 YRS.					July	10	1969	6:42 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑	9. COUNTY OF DEATH
Balto, Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Port Deposit	Spot-In-the-Rock-Tavern	Laborer	?

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Port Deposit	YES ☐ NO XX	Spot-In-the-Rock-Tavern

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	H.	Love	Ellen	M.	Payne

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
yes	W.W 2	220-12-5397	Mrs. Ona L. Jones	1517 Presser Ct.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot wound of the chest
965X
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES XX NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	4:30 P.M. 7 10 1969	Subject shot during argument

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Tavern	Rte. 269	Port Deposit	Cecil	MD.

22a. I certify that I took charge of the remains described above, held an Autopsy XX Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide XX Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22b. DATE SIGNED July 11, 1969

EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner
ADDRESS (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-16-69	National Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
RANDOLPH J. COLLICK	243 E. OLIVER ST.	JUL 17 1969	[signature] Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

[redacted] 09750

CERTIFICATE OF DEATH

09746

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
William	NMI	MacBRIDE	July 27, 1969	6:35 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	February 28, 1910	59 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Penna.	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Perry Point	VA Hospital	Steam fitter	Boiler

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Harford	Havre deGrace	YES ☒ NO ☐	202 N. Washington

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	NMI	MacBride	Maude		Kuhn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW 2	161 09 5527	VA Hospital Records, Perry Point, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Thrombosis - Arteriosclerotic heart	
DUE TO, OR AS A CONSEQUENCE OF (b)	disease with fibrosis of myocardium	
DUE TO, OR AS A CONSEQUENCE OF (c)	Infarction, remote	

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost. 433.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	XXXX				

22a. **I certify** that (I) (this hospital) attended the deceased from July 25, 19 69, to July 27, 19 69, and that to the best of my knowledge and belief death occurred at the hour and date stated above, and the cause of death is as stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
S. Goldgraben	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	7-28-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
S. GOLDGRABEN, M.D.	c/o VA Hospital, Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/30/69	Angel Hill Cemetery	Havre de Grace, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PENNINGTON & SON Havre De Grace, Md.	JUL 31 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

#1 12

Item2a FilmG415

[redacted] 09751

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09747

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First: Frederick	Middle: Willian	Last: Marklin, JR.	2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ Month: 7 Day: 12 Year: 1969	2b. HOUR: M						
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: 6-20-33	6. AGE (In years last birthday): 36 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 7 Day 14 Year 1969	2d. HOUR: 9:40 PM				
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.								
10. CITY OR TOWN OF DEATH: ELKTON, MD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ACCOUNTANT	12b. KIND OF BUSINESS OR INDUSTRY: —								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: CALF.	13b. COUNTY: —	13c. CITY OR TOWN: SAN-MATEA	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 3677 F. EDISON							
14. FATHER'S NAME First: FREDERICK	Middle: WILLIAM	Last: MARKLIN SR.	15. MOTHER'S MAIDEN NAME First: MARIAN	Middle:	Last: DEARDYNE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES	(If yes give war or dates of service): 1955 - 1957	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: NANCY B. MACKLIN	ADDRESS: SAN MATEA CALF.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8320
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
	3:30 P.M. 7 12 1969	fell overboard while sailing

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	water	Rocky Point, Northeast River		Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 7/15/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7-18-69	OAKLAND	WEST GOSHEN CHESTER PA.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
R.T. FORD FUNERAL HOME Robert T. Ford	CHESAPEAKE CITY	JUL 18 1969	[signature]

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
[redacted] 09752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09748

1. DECEASED-NAME (Type or Print)	First: Marie	Middle: Ryan	Last: Miles	2a. DATE KNOWN OF DEATH ESTIMATED ☑	Month: 7	Day: 21	Year: 1969	2b. HOUR: 8:10 A.M.			
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: 9-24-16	6. AGE (In years last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month 7	Day 21	Year 1969	2d. HOUR: 8:20 A.M.		
7a. BIRTHPLACE (State or foreign country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil, Md.								
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Accountant	12b. KIND OF BUSINESS OR INDUSTRY: Auto-Retail								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Pa.	13b. COUNTY: Chester	13c. CITY OR TOWN: West Chester	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: 307 Westtown Rd.							
14. FATHER'S NAME First: Howard	Middle: M.	Last: Ryan	15. MOTHER'S MAIDEN NAME First: Edna	Middle:	Last: Pollock						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 173-07-0289	17. INFORMANT: John B. Miles (husband)	ADDRESS: 307 Westtown Rd. West Chester, Pa.								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hepatic coma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Cancer of Lung with — 4 mos.

DUE TO, OR AS A CONSEQUENCE OF (c): Metastases to Liver

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.

EXAMINER'S NAME (Type): John M. Byers, MD.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ADDRESS (Street, city, town, or county): Elkton, Md.

22b. DATE SIGNED: July 21, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
CREMATION	JULY 24, 1969	WEST LAUREL HILL CREMATORY	BALA CYNWYD, PA

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME Donald Pippin	ELKTON Md	JUL 23 1969	Charles Jones

VR A15ME (5)
10M REV. 1/68

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

[redacted] 09753 09749

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
EMMA	GERTRUDE	MINKER	JULY	17,	1969	8:30A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	DEC. 21, 1872	96 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
ELKTON	UNION HOSP.	HOUSEWIFE	AT HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
Md.	CECIL	ELKTON		240 E. HIGH ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
STEPHEN		DICKS	CLARA		WIRE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	WA077969	MRS. HERBERT J. MORGAN	ELKTON Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malnutrition - Emaciation
DUE TO, OR AS A CONSEQUENCE OF (b) Senility
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 440.9
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Aug, 1962, to July 17, 1969, that (I) (we) last saw the deceased alive on 7/17/1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		☒	☐	☐	7/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOSEPH G. LANZI	ELKTON MEDICAL PARK, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	7/21/69	ELKTON CEMETERY	ELKTON CECIL Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON, Md.	JUL 22 1969	(Charles Judge)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[redacted] 09754

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09750

1. DECEASED-NAME (Type or print)	First: JOSEPH	Middle:	Last: MONTE	2a. DATE OF DEATH: Month 7 Day 1 Year 69	2b. HOUR: 8:30am M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 7-12-00	6. AGE (In years last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS 11 DAYS 18	IF UNDER 24 HRS.: HOURS MIN	
7a. BIRTHPLACE (State or foreign country): Italy	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: Perry Point	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Restaurant worker	12b. KIND OF BUSINESS OR INDUSTRY: RESTAURANT			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: District of Columbia	13b. COUNTY	13c. CITY OR TOWN: Washington	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1525 Penna. Ave., SE		
14. FATHER'S NAME First: Anthony	Middle:	Last: Monte (D)	15. MOTHER'S MAIDEN NAME First: LAGNE	Middle: FLORINDA	Last: [redacted] (D)	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW II	16b. SOCIAL SECURITY NO.: 181-03-3515	17. INFORMANT: VA Hospital Records, Perry Point, Md.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia of right lung, severe.

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Malnutrition, anemia, and debility secondary to two major operations, Viz, left Pneumonectomy for CA of left lung (1967) and sub-total gastrectomy 1961.

DUE TO, OR AS A CONSEQUENCE OF (c): Nutritional cirrhosis of liver, severe.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from April 28, 19 69, to July 1, 19 69, that (I) (we) last saw the deceased alive on [illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. L. Mooney, M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 7-1-69	
22d. PHYSICIAN'S NAME (Type): A. L. MOONEY, M.D.	22e. ADDRESS: VA Hospital, Perry Point, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 7/4/1969	23c. NAME OF CEMETERY OR CREMATORY: BALTIMORE NATIONAL CEMETERY	23d. LOCATION (City or Town) (County) (State): BALTIMORE, MD.	
24. FUNERAL DIRECTOR: Hyson Funeral Home, Washington, DC	ADDRESS: Thomas M. Hyson	25a. REC'D BY REGISTRAR DATE: JUL 7 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (1) 45M - 1/69

Monotonic trends of right ventricle.

[redacted] 09755

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09751 7/23/69

CERTIFICATE OF DEATH

Pronounced dead 12:15 A.M.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month Day Year	2b. HOUR
REUBEN	HUBERT	PAFFENROTH	July 22 1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	Cau	12 February 1926	43 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
New York	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Bainbridge, Maryland	Commissary Store, NTC	Retired Navy	--

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Cecil	Rising Sun	YES [ ] NO [X]	RD#2, FOOTS ROAD

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
HENRY	(n)	PAFFENROTH	MARIE	(n)	WEITZ

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes 2/12/46 - 3/4/66	090 20 8427	Wife Nancy C. PAFFENROTH	Rising Sun, RD#2, FOOTS ROAD Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	Immediate
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	No

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify ~~that (I) (this hospital) attended the deceased from ---------- 19---, to ---------- 19---~~, that (I) ~~(XX)~~ last saw the deceased alive on July 17 1969 and that in (my) ~~(XX)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(was)~~ did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dayce B Tollison		[ ]	[X]	[X]	23 July 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
B. G. TOLLISON LT MC USNR	Station Dispensary, Naval Training Center, Bainbridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7-26-1969	Asbury Cemetery	Port Deposit Cecil Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
LEE A. PATTERSON & SON FUNERAL HOME,	Perryville, MD.	JUL 28 1969	Wanda Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
30M REV. 1/68

09256

[redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09752

1. DECEASED-NAME (Type or print): First: Lewis; Middle: ; Lost: Pennock

2a. DATE OF DEATH: Month: July; Day: 29; Year: 1969

2b. HOUR: 6:30 AM

3. SEX: Male

4. RACE: White

5. DATE OF BIRTH: Nov. 27, 1888

6. AGE (In years lost birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN

7a. BIRTHPLACE (State or foreign country): Del.

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: Cecil Md.

10. CITY OR TOWN OF DEATH: Perryville

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): R.D. # 1

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carpenter

12b. KIND OF BUSINESS OR INDUSTRY: Building

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.

13b. COUNTY: Cecil

13c. CITY OR TOWN: Perryville

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET AND NUMBER: R.D. # 1

14. FATHER'S NAME First: Alpheus; Middle: ; Lost: Pennock

15. MOTHER'S MAIDEN NAME First: Margaret; Middle: J.; Lost: Little

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 217-01-4504

17. INFORMANT: Delena E. Pennock Address: R.D. # 1 Perryville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic failure
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of the stomach with metastases.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 151.9
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertensive cardiovascular disease, diabetes mellitus

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospitol) ottended the deceased from 1-16, 1969, to 7-29, 1969, that (I) (we) last saw the deceased alive on 7-28 1969, and that in (my) (our) opinion death accurred on the date ond hour ond from the causes stated abave. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jay S. Barnhart, Jr. M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 7-29-69

22d. PHYSICIAN'S NAME (Type): Jay S. Barnhart Jr.

22e. ADDRESS: 4 Mauldin Ave. North East, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 8-1-69

23c. NAME OF CEMETERY OR CREMATORY: White Clay Creek

23d. LOCATION (City or Town) (County) (State): Newark New Castle Del.

24. FUNERAL DIRECTOR: Grant Funeral Home ADDRESS: Paul V. Crouch Box 250 North East, Md.

25a. REC'D BY REGISTRAR DATE: AUG 1 1969

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

[redacted] 9757

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09753

CERTIFICATE OF DEATH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Mary	Middle: M	Last: Potts	2a. DATE OF DEATH Month: 7 Day: 15 Year: 1969	2b. HOUR: 6:35 P.M.
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: 1/28/04	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Delaware	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Kent	13c. CITY OR TOWN: Millington	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: R.F.D. 2	
14. FATHER'S NAME First: JAMES	Middle:	Last: SULDER	15. MOTHER'S MAIDEN NAME First: MARY	Middle:	Last: —
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: YES	17. INFORMANT: Samuel Potts	Address: Millington md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon with Metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8-Months
1538
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cardiac — 8-Months
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 3/29/ 19 69, to 7/15/ 19 69, that (I) ~~(we)~~ last saw the deceased alive on 7/15/ 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: James L. Johnson M.D.	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 7/16/69
22d. PHYSICIAN'S NAME (Type): James L. Johnson M.D.	22e. ADDRESS: 245 E. High St., Elkton Cecil Md.				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 7/19/1969	23c. NAME OF CEMETERY OR CREMATORY: Graves Chapel	23d. LOCATION (City or Town): Millington	(County): Kent Md. (State)
24. FUNERAL DIRECTOR: Bennett Sadler	ADDRESS: Chestertown, md	25a. REC'D BY REGISTRAR DATE: JUL 23 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
30M REV. 1/68

1

09758 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09754

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First: HERBERT Middle: LEE Last: REEVES	2a. DATE OF DEATH Month: 7 Day: 18 Year: 69	2b. HOUR 10:40 A.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 17, 1969	6. AGE (In years last birthday) — YRS. IF UNDER 1 YEAR: MONTHS 0 DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Md	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CECIL Md.
10. CITY OR TOWN OF DEATH: ELKTON	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): UNION HOSP	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: CECIL	13c. CITY OR TOWN: ELKTON	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: UNION HOSP.
14. FATHER'S NAME First: HERBERT Middle: G. Last: REEVES	15. MOTHER'S MAIDEN NAME First: BERTHA Middle: FAYE Last: TACKETT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: HERBERT G. REEVES ELKTON, Md	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 36 hours
7762
DUE TO, OR AS A CONSEQUENCE OF
(b) Prematurity
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** thot (I) (this hospitol) attended the deceased from 7-17-, 1969, to 7-18-, 1969, that (I) (we) last saw the deceased alive on 7-18- 1969, and thot in (my) (our) opinion death occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Tillman D. Johnson M.D.	ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐	22c. DATE SIGNED: 7-21-69	
22d. PHYSICIAN'S NAME (Type): Tillman D. Johnson M.D.	22e. ADDRESS: 173 S. Liberty Ave Elkton, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 7/22/69	23c. NAME OF CEMETERY OR CREMATORY: UNION CEMETERY	23d. LOCATION (City or Town): UNION	(County): CECIL (State): Md
24. FUNERAL DIRECTOR: PIPPIN FUNERAL HOME	ADDRESS: ELKTON Md.	25a. REC'D BY REGISTRAR DATE: JUL 23 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)-30M REV. 1/68

[redacted] 09755

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Lost	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR
Eunice		Richardson	July	8	69	2:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	9/16/02	66 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
N. Carolina.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Practical Nurse	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER
Penna.	Chester			R.D. #2

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
William	R.	Bowers	Phoebe		Wyatt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	212 24 9616	Albert B. Garver	Elkton, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA Colon with metastases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Months
1538
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. **I certify** thot (I) (this hospitol) ottended the deceased from 6/21, 19 69, to 7/8, 19 69, that (I) (we) last saw the deceased alive an 7/8 19 69, and that in (my) (our) opinian death occurred an the date and haur and from the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☑	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
John A. Fischer, M.D.					7/8/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A. Fischer.	ELKTON, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	7/11/69	Conowingo Baptist Church Cemetery	Conowingo	Cecil	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks	Hicks Home for Funerals, Elkton, Md	JUL 15 1969	Alexander Judge

VR A15 M
30M REV. 1-68

09760 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09756

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremotian, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Mary Roman	Middle:	Lost:	2a. DATE OF DEATH Month: July	Day: 29	Year: 1969
2b. HOUR: 11:20 A.M.					
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Aug. 26, 1881	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Rissia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Cecil Md.		
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Union Hospital	12a. USUAL OCCUPATION (Kind of work done durin/ most of workin/ life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R.D. # 1	
14. FATHER'S NAME First: Unknown	Middle:	Lost:	15. MOTHER'S MAIDEN NAME First: ANNA	Middle:	Lost: Barwick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Martha R. Cann	Address: R.D. #1 Elkton, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Min.

Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse lost. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Occlusion — 5 Min.

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Heart Disease — ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / Stote	

22a. **I certify** thot (I) (this haspital) attended the deceased from 3/20, 1967, to 7/29, 1969, thot (I) (we) last sow the deceased alive on 7/29 19 69, and thot in (my) (our) opinion death occurred on the date and hour and fram the couses stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Peter Stavrakis	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 7/30/69	
22d. PHYSICIAN'S NAME (Type): Peter Stavrakis	22e. ADDRESS: Elkton, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Aug. 1, 1969	23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor MEM. PK.	23d. LOCATION (City or Town): Elkton	(County): Cecil (State): Md.
24. FUNERAL DIRECTOR: Pippin Funeral Home	ADDRESS: Elkton, Md.	25a. REC'D BY REGISTRAR DATE: AUG 4 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 30M REV. 1/68

1

FOR STATE HEALTH DEPT.

09761 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09757

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
Hugh	Raymond	Schmidt	☑ / ☐	7	31	1969	3:18 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
M	W	12-26-14	54 YRS.			7 / 31 / 1969	3:18 A.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Iowa	U.S.A.	MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hosp.	Foreman	Steel Tubing

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pa.	Montgomery	Schwenksville	YES ☑ NO ☐	Summit Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Nelson		Schmidt	Carol		Weida

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	—	178-03-8474	Katherine Schmidt	Schwenksville, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** thot I took chorge of the remoins described obove, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinian deoth resulted from: Noturol couses ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE John M. Byers, M.D.
EXAMINER'S NAME (Type) John M. Byers, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 7-31-69
Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	8/4/69	Edgewood Cemetery	Pottstown, Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	AUG 4 1969	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

[redacted] 09762

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 11 FilmG415 8/8/69 kk

CERTIFICATE OF DEATH

09758

1. DECEASED-NAME (Type or print)	First: Albert	Middle: Kyle	Last: Schuman, Sr.	2a. DATE OF DEATH: Month July Day 28 Year 1969	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Dec. 8, 1923	6. AGE (In years last birthday): 45 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.			
10. CITY OR TOWN OF DEATH: North East	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 322 E. Cecil Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Sanitation Truck	12b. KIND OF BUSINESS OR INDUSTRY: Own			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Rising Sun	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Red Pump Road		
14. FATHER'S NAME First: Frank	Middle	Last: Schuman	15. MOTHER'S MAIDEN NAME First: Lucy	Middle	Last: Reed	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-14-4965	17. INFORMANT: Mrs. Albert Schuman, Sr.	Address: Rising Sun, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary sclerosis — 2 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c):

4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-15, 1968, to 7-28, 1969, that (I) (we) last saw the deceased alive on 7-27 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Neil R. Taylor, Jr.	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	7-29-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil R. Taylor, Jr.	Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Jul 31, '69	Brookview Cemetery	Rising Sun Cecil Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Vernon E. McMullen	Rising Sun, Md.	AUG 1 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09763 09759

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: George	Middle: R.	Last: Scott	2a. DATE OF DEATH Month: July Day: 11, Year: 1969
2b. HOUR: M	3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Sept. 28, 1903
6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Cecil Md.
10. CITY OR TOWN OF DEATH: Elkton	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Union Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carpenter	12b. KIND OF BUSINESS OR INDUSTRY: Building
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Cecil	13c. CITY OR TOWN: Elkton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Fair Hill R.D.4			
14. FATHER'S NAME First: Leroy	Middle: H.	Last: Scott	15. MOTHER'S MAIDEN NAME First: Amanda Middle: Rebecca Last: Holland
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 222-01-2886	17. INFORMANT Address: Mrs. Ruby F. Scott, Elkton, Md. R.D.4	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days.
4123
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): Pulmonary Embolism — 1 week
DUE TO, OR AS A CONSEQUENCE OF (c): ASHD — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Carcinoma of the Colon

19a. DATE OF OPERATION: 4,15,8,7/69	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma of the Colon	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this haspital) attended the deceased fram 4/30, 19 69, to 7/11, 19 69, that (I) (we) last saw the deceased alive an 7/11 19 69, and that in (my) (aur) apinion death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE: Rolando A. Najera M.D.	DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 7/15/69	
22d. PHYSICIAN'S NAME (Type): Rolando A. Najera	22e. ADDRESS: 105 Main St. Elkton, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 7/15/69	23c. NAME OF CEMETERY OR CREMATORY: St. John's Meth. Cemetery	23d. LOCATION (City or Town): Lewisville	(County): Cecil	(State): Md.
24. FUNERAL DIRECTOR: Ralph E. Hicks	ADDRESS: Hicks Home for Funerals, Elkton, Md.	25a. REC'D BY REGISTRAR DATE: JUL 22 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

[redacted] 03764

CERTIFICATE OF DEATH

09760

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Peter	Elias	Tome	July	3	1969	3P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN
Male	White	April 5, 1897	72 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rising Sun	Farmington Road	Public Works Ret.	Civil Ser.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Rising Sun	YES ☐ NO ☒	R.F.D. # 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Jacob	Eli	Tome	Judith		Woodrow

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes W.W. 1	214-16-3914	Mrs. Peter Tome Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hours

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) ASHD — 3 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4-12, 1962, to 7-3, 1969, that (I) (we) last saw the deceased alive on 7-3 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Neil R Taylor		☒	☐	☐	7-4-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Neil R Taylor Jr	Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 6, 1969	Hopewell Cemetery	Port Deposit, Cecil, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Thomas E. Mullen	Rising Sun, Md.	JUL 8 1969	Clerk Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 72 hours after death.

VR A1514
30M REV. 1-68

1 3 Item2a FilmGill 7/25/69 dck

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

61 83 3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09761

[redacted] 09765 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b. HOUR
Joseph	Kenneth	~~Vargas~~	☒	7	?	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
male	white	July 24, 1946	22 YRS.			7	13	1969	6:00p

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Washington, D. C.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Auto Mechanic	Auto

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Va.	Prince Wm.	Woodbridge	YES ☐ NO ☒	341 Puds Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ben		Vargas	Kate		Matherly

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
no		Mrs. Lynn Vargas, Woodbridge, Virginia

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Intravenous narcotism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 304.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county)

22b. **DATE SIGNED** 7/14/69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 16, 1969	Fairfax Memory Gardens	Fairfax County, Virginia

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
RIPPIN FUNERAL HOME [signature] Elkton, Md.	JUL 17 1969	[signature] Judge

VR A15ME (5)
10M REV. 1/68

FOR STATE HEALTH DEPT.

09766 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09762

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month	Day	Year	2b. HOUR
ALLEN	E.	WALTON	July	18	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
Male	White	Jan. 18, 1934	35 YRS.			July 18 1969	2:16 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Pennsylvania	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Maintenance	Pepperidge Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Pa.	Chester	Downingtown	YES [X] NO [ ]	12 King St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Earl	A.	Walton	Ada		Todd

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
Yes	Korean		Mrs. Mary Z. Walton, 12 King St.	Downingtown, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning
910.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
	12:30 7-18-69	Drowned while swimming

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Northeast River near McDaniels Yacht Basin		Northeast	Cecil	Md.

22a. I certify that I took charge of the remains described above, held on Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinian death resulted from: Noturol couses [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 7-19-69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/23/69	Hopewell Meth. Cemetery	Downingtown, Chester, Penna.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD. BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Maryland	JUL 23 1969	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item6 FilmG415 8/8/69kk 09763

CERTIFICATE OF DEATH

09763

1. DECEASED-NAME (Type or print): First EVA Middle Lost WATERS
2o. DATE OF DEATH: Month 7 Day 24 Year 69
2b. HOUR: 4:12 P.M.
3. SEX: F
4. RACE: NEGRO
5. DATE OF BIRTH: 8-10-1906
6. AGE (In years last birthday): 62 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7o. BIRTHPLACE (State or foreign country): MD
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CECIL MD Md.
10. CITY OR TOWN OF DEATH: ELKTON MD
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): ELTON HOSPITAL
12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY: DEAN
13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD
13b. COUNTY Harford
13c. CITY OR TOWN Street
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: BOX 225
14. FATHER'S NAME First Walter Middle Lost Waters
15. MOTHER'S MAIDEN NAME First Margert Middle Lost Kenly
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 236-30-2235
17. INFORMANT: Sarah Barnes Address: Street md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) MESENTERIC THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS
DUE TO, OR AS A CONSEQUENCE OF
(b) CHRONIC CARDIOVASCULAR DISEASE — SEVERAL YEARS
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19o. DATE OF OPERATION: NONE
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20o. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OE OEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospitol) attended the deceased from 7/22, 19 69, to 7/24, 19 69, thot (I) (we) lost sow the deceased alive on 7/24 19 69 and thot in (my) (our) opinion death occurred on the date ond hour and from the couses stoted above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. V. Davis MD — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 7/28/69
22d. PHYSICIAN'S NAME (Type): HENRY V. DAVIS MD
22e. ADDRESS: CHESAPEAKE CITY MD

23o. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 7-28-69
23c. NAME OF CEMETERY OR CREMATORY: CEDARS Church
23d. LOCATION (City or Town) (County) (Stote): DARLINGTON Hz MD
24. FUNERAL DIRECTOR ADDRESS: George W Tittle Bel Air Md
25o. REC'D BY REGISTRAR DATE: AUG 5 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 30M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1a. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09764

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month	Day	Year	2b. HOUR					
FRANKLIN	TAYLOR	WILLIAMS, JR.	7/23		69	M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
Male	White	April 1, 1921	48 YRS.					July	23,	19 69	1:45 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH	
Maryland	U.S.A.		CECIL	Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
	1/4 mi. N. of Elk Forest Rd.	Owner	Williams Motor Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
Md.	Cecil	Elkton		120 Walnut Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last			
Franklin	T.	Williams	Ella		Simmers			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WW II		120 Walnut Lane Mrs. Florence H. Williams, Elkton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gunshot wound of head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 985X

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
	? 7-23 19 69	?	

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town	County	State
	auto 1/4	mi. N. of Elk Forest Rd.	Cecil	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [X]

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER [ ]

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED July 24, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	7/26/69	Gilpin Manor Memorial Park, Elkton, Md.			

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	JUL 30 1969	Charles Judge	

10768

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item2a Film G415 8/1/69 kk

CERTIFICATE OF DEATH

09765

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
William	H.	Wilson	July	20	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	Negro	June 15, 1916	53 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	U.S.A.		Cecil Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospt.	Aide in Hospt.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Md.	N.C. Cecil	Elkton	X	110 Bell's Lane

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William D. Wilson			Lucy Anderson		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes WW2	218-05-6682	Ruth Wilson	110 Bell's Lane

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	2 hours
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Arteriosclerosis	8 years
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 1965, to 7-20, 1969, that (I) ~~(we)~~ last saw the deceased alive on 7-16 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Williford Eppes	MD	☒	☐	☐	7-24-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Williford Eppes	Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/24/69	Providence Cem.	Elkton, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Colvin R. Bell	Wilmington, Del 909 Poplar St.	DATE JUL 28 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

09770 [redacted]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09766

1. DECEASED-NAME (Type or Print) First	Middle	Lost
CHARLES	EDWARD	WYANT

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month July Day 12 Year 1969 — 2b. HOUR M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	IF UNDER 1 YEAR: DAYS	IF UNDER 24 HRS.: HOURS	IF UNDER 24 HRS.: MIN.
Male	White	June 2, 1936	33 YRS.				

2c. DATE PRONOUNCED DEAD Month July Day 12 Year 19 69 — 2d. HOUR 11:00 P.M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
West Virginia	U.S.A.		CECIL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Elkton	Union Hospital	Barrett Paper Co. Lmt.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Cecil	Elkton	YES ☐ NO [X]	Rd. #5 (Cherry Hill)

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Lonnie	W.	Wyant	Middie		Rakes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
	233-54-9789	Mrs. Velma Y. Wyant, Elkton, Md. R.D. # 5

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Electrocution
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 9250
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR XXX 9:50 P.M. 7/12 19 69	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
		Cutting power lines, contacted live wire

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Home	XX Whitehall Rd. Extension	Elkton		Md.

22a. **I certify** thot I took chorge of the remoins described above, held on Autopsy [X], Inspection ☐, Inquiry ☐, ond in my opinion deoth resulted from: Noturol couses ☐, Accident [X], Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Werner U. Spitz M.D.

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER [X]
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED July 14, 1969

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7/16/69	Elkton Cemetery	Elkton Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REG'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	JUL 22 1969	[signature]

VR A15ME (5) 10M REV. 1/68

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pag. 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.